

**Investigation into the circumstances surrounding
the death of a man at HMP Elmley
in April 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2010

This is an investigation into the death of the man, who died at HMP Elmley in April 2009. He was 29 years old and had only been at Elmley for three days.

I would like to offer my sincere condolences to the man's family. I also apologise for the delay in issuing this report, and for any additional distress this may have caused.

The investigation was conducted by my investigator. I would like to thank the Governor of Elmley and the prison's liaison officer for the assistance they provided during the investigation. Eastern and Coastal Kent PCT were commissioned to produce a clinical review of the care of the man received while he was at Elmley. They appointed the clinical reviewer and I am grateful to her for her contribution to this report.

The man was arrested for a sexual offence and had a history of mental health problems. In addition, it was his first time in prison, he was clearly distressed and it was a Bank Holiday weekend. All these factors were apparent when he arrived at reception, but Assessment, Care in Custody and Teamwork (ACCT) monitoring was not arranged. (ACCT is the Prison Service's monitoring procedure for people seen to be at risk of suicide or self harm.) Instead, the reception nurse thought that the best course of action was to locate him in healthcare at Elmley, where he could be assessed more thoroughly by healthcare staff.

There appears to have been a breakdown of communications. The man stayed in healthcare but, before he had a psychiatric assessment, he was taken to a house block where he was put alone in a single cell. None of the staff appear to have spoken to him before he was locked up for lunch, although it was clear that he wanted to do so. When his cell was unlocked that afternoon, he was found with a ligature tied around his neck.

I make five recommendations, two to the Governor, two to the Head of Healthcare and one to both. These include opening an ACCT, healthcare issues and first aid training.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Deputy Ombudsman

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CONTENTS

Summary

The Investigation Process

HMP Elmley

Key Findings

Issues

Conclusion

Recommendations

SUMMARY

The man was arrested for an offence on 20 March 2009. He reported to the police on 9 April where he was charged and remanded into custody at HMP Elmley. It was the Good Friday of an Easter Bank Holiday weekend.

The man had been under the care of a psychiatrist for psychiatric problems and diagnosed with a multiple personality disorder. When he arrived at Elmley, he disclosed that his mood was low, he was anxious and ashamed of the offence, and had not been in prison before. Documents from the police and Sittingbourne Magistrates' Court indicated that the man had previously attempted to take his life and that there was a possibility that he would again try to harm or attempt to kill himself.

During his reception at Elmley, the man requested Rule 45 status, due to the nature of his offence and because he lived and worked near the prison. (Rule 45 is explained later in my report. It allows prisoners to be segregated for their own protection.) The application was granted. The reception nurse remained concerned about him and, instead of locating him on house block one (the spur for vulnerable prisoners), decided to admit him to healthcare. The nurse wanted him to have a mental health assessment. He did not begin the Assessment, Care in Custody and Teamwork (ACCT) procedures, as he believed that the man would be assessed in healthcare and so an ACCT would not be necessary.

Whilst in healthcare, the man saw two mental health nurses who spoke to him but did not assess him fully. He was also seen by a doctor who judged that he had no mental health problems and was fit to leave healthcare for normal location. The next day, Easter Sunday, the man moved to house block one and was located in a single cell. It is not clear whether he spoke to a member of staff at any point, although he did have a conversation with another prisoner. At approximately 12.30pm, all the prisoners on the house block were locked in their cells for lunch. As it was a Sunday, and therefore a weekend regime, they were not unlocked for association (when they have free access with other prisoners) until 3.30pm.

Whilst unlocking prisoners for association, an officer came to the man's cell and could elicit no response. The officer quickly became concerned and asked another officer to unlock the cell with him. They found that the man had suspended himself to the back of the toilet door, using a ligature made from a bed sheet. Assistance arrived quickly, but despite the efforts of staff and paramedics, the man could not be resuscitated. He was pronounced dead at 6.10pm by a duty doctor.

I make five recommendations. They concern opening the ACCT procedures, transferring prisoners from healthcare to a house block, the personal officer scheme and first aid training for staff.

THE INVESTIGATION PROCESS

1. My investigator was appointed to conduct this investigation. She visited the prison on 17 April 2009 to visit the cell where the man died, meet with some key staff and collect all the prison documentation.
2. Notices were issued to both prisoners and staff inviting anyone who had information regarding his death to make themselves known to the investigator. Two prisoners asked to speak to my investigator.
3. My investigator visited Elmley on 15 and 16 June, and 12 August to carry out recorded interviews with staff.
4. The Ombudsman's senior family liaison officer, contacted the man's family to explain the role of the Ombudsman and to offer the opportunity to participate in the investigation and raise any concerns they might have. My investigator and the Ombudsman's senior family liaison officer met the man's wife, mother and father-in-law on 6 August. The man's father-in-law wanted to know why the man was not considered to be suicidal in the light of the information passed to the prison about his mental health and also why nobody had checked on him after he moved from healthcare to the house block. The man's father-in-law was anxious to know what happened to the man whilst he was in healthcare, why he moved to a wing and what assessment was carried out when he came into prison. The man's wife asked what qualifications the healthcare staff have in order to make mental health assessments. She also asked whether her husband had left a letter.
5. The man's father-in-law also commented on the treatment of his daughter and the man by the police and had a number of other issues which he wanted to raise. The Ombudsman's senior family liaison officer explained that they were not within the Ombudsman's Terms of Reference and agreed to forward the contact details for the Independent Police Complaints Commission.
6. On 20 August, the man's father-in-law rang the Ombudsman's office and spoke to another Ombudsman's family liaison officer. He told her that on the day the man was sent to Elmley, his barrister signed his escort document saying that his son-in-law was at risk of harming himself. The man's solicitors later wrote to the prison to ask whether this documentation had arrived at Elmley. The prison wrote back to confirm that it had.
7. Eastern and Coastal Kent Primary Care Trust were commissioned to conduct a clinical review and appointed a general practitioner and clinical advisor to the PCT, to conduct the review. The clinical reviewer and my investigator, carried out a number of joint interviews with healthcare staff.

HMP ELMLEY

8. HMP Elmley is the largest of three prisons located on the Isle of Sheppey. It opened in 1992 and is a local prison for all of Kent with a capacity of 985 prisoners. There are five residential house blocks, one of which contains a spur where vulnerable prisoners are located (this enables vulnerable prisoners to live away from other prisoners for their own protection), a healthcare unit and a segregation unit. The prison has a chaplaincy department and ministers are available from most denominations or faiths.

Healthcare

9. Healthcare in the prison is commissioned and provided by the Eastern and Coastal Kent Primary Care Trust. The healthcare centre includes a 29 bed inpatient unit, treating patients with both physical and mental health needs. Every prisoner at Elmley has an initial health screen in reception to determine if they have any immediate physical needs to be addressed, such as injuries or withdrawal from alcohol or drugs. An assessment of any evidence of mental health needs or issues relating to the risk of the prisoner harming themselves is also made.

Reception and induction procedures

10. All prisoners arriving at Elmley are processed through the reception area, including those returning to the prison following court appearances or medical appointments. The purpose of reception is to check the identity of, and the accompanying paperwork for, each prisoner and gather important information about their health, state of mind and risk – to themselves and others – before they are allocated to a cell in the prison. Whilst in reception, new prisoners undergo a first reception health screen with a nurse (this is to identify any presenting physical or mental health issues that may need further assessment by a doctor or other specialist mental health service. Staff also carry out a Cell Sharing Risk Assessment (CSRA), which assesses the risk a prisoner may pose to other prisoners and thus their suitability to share a cell.
11. All prisoners are given an induction to the regime at Elmley. This usually takes place in their first few days, when they will be told about prison life, how to access services and ways in which they can receive help.

Assessment, Care in Custody and Teamwork (ACCT)

12. ACCT is the Prison Services' care planning system whereby staff can work together to provide individual care to prisoners who are identified as being at risk of harming themselves or of suicide. Any member of staff in the prison, including doctors and healthcare staff, can open an ACCT on a prisoner. The ACCT procedures include regular meetings and discussions with the prisoner, monitoring in between times and support such as access to Listeners. Meetings are scheduled to monitor and review the prisoner's care and progress.

Listeners

13. A number of prisoners at each prison are trained and supported by the Samaritans to be Listeners and to offer peer support. Other prisoners can speak to a Listener in confidence about any issues that affect them. Listeners are bound by confidentiality rules, like the Samaritans, and are unable to disclose any details about conversations they have had (unless it is a matter which affects the security of the prison). Listeners can refuse to see a prisoner if they wish.

Rule 45

14. Previously known as Rule 43, this allows prisoners to be segregated from other prisoners for their own protection. House block one has a spur for all rule 45 prisoners to be located.

Her Majesty's Chief Inspector of Prisons (HMCIP)

15. Elmley was most recently inspected by HM Inspectorate of Prisons in an unannounced short follow-up inspection in April 2009. In her report, the Chief Inspector, said:

“Elmley had made good progress on many of our recommendations to improve safety. Early days in custody were generally well managed ... However, the holding cells in reception remained grubby, and first night processes needed further tightening.

“Tragically, there had been three deaths in custody since our last visit, but we nevertheless identified some improvements in suicide prevention procedures.”

16. With regard to the personal officer and prisoner relationship, the report said:

“The personal officer scheme had been updated in December 2007 and was due to be reviewed in December 2009. Although all prisoners were allocated a personal officer, the quality of entries and engagement with prisoners varied considerably.”

17. The report also included a recommendation that mental health services should include the provision of primary mental health services. It noted that:

“The current mental health team was unable to meet the needs of all prisoners, but worked well with the mental health in-reach team to manage prisoners with mental health needs.”

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board, which is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The latest IMB report covers the period November 2007 to October 2008. The Board's overall impression was that a number of managerial changes had hindered the progress of the prison. They commented on an inconsistent personal officer scheme, the centralisation of certain services due to clustering of the prisons on the Isle of Sheppey and insufficient discipline staff to manage basic services, such as library services.
19. In particular, the IMB commented on healthcare provision at Elmley. They said that it had been a challenging year for healthcare staff and that staff have to manage the needs of very complex and challenging patients. The IMB noted that the Mental Health Team is a developing service which provided basic screening at that time, however further recruitment and investment was planned.
20. Safer Custody meetings were considered to be well organised and attended, with prisoner representatives taking an active role in the meetings.

KEY FINDINGS

21. The man was described by his family as an intelligent and gentle man, who had been with his partner for 13 years. He had sought psychiatric help for issues arising from his childhood, and been diagnosed with a multiple personality disorder. Following a disclosure to a psychiatrist (about the offence for which he was charged), police visited his flat and arrested him on 20 March 2009. He was questioned at Sittingbourne Police Station, where he admitted the offence and was released on bail. He also signed the Prisoner Escort Record (PER) which explained that he was suicidal and had mental health problems.
22. The man was required to report again to the police on Thursday 9 April, when he was charged with the offence and remanded into custody. He appeared at Sittingbourne Magistrates' Court where he was remanded in custody for a number of offences. He arrived at Elmley prison later in the day at approximately 5.50pm.
23. A Prisoner Escort Record form (PER, a record of events at court and information about the prisoner) and a Suicide/Self Harm Warning form accompanied the man to the prison. The PER form showed that, whilst at court, he declined any food, drink or reading material. At 4.26pm, he had a legal visit from his solicitor. The solicitor was concerned enough about the man to raise his concerns with a custody officer at Sittingbourne Magistrate's court.
24. A Suicide/Self Harm Warning form was opened by the custody officer, at 4.50pm. He indicated that he was concerned that the man seemed very depressed, in particular about the charges against him. The custody officer noted that the man had been subject to "intermittent" observations whilst at court and made the following note on the form:

"The solicitor who is the man's representative stated to me the custody officer said that the man said that he is a risk to himself and nobody else. I understood that to mean that he would possibly try to harm himself."
25. The front page of the PER indicated that the man was a security risk (violence and conceals weapons indicators were ticked) and was a risk of suicide or self harm. Further information written on the form said "Consider as a rule 43. Has suicidal thoughts and attempts in the past."
26. The man departed for the prison at 5.00pm. An hour later he saw the Senior Officer in the prison reception. The SO in the prison reception told the investigator that he received the PER form and the Suicide/Self Harm Warning form. He recalled seeing the note that the man should be considered a rule 43 prisoner (now referred to as rule 45). The SO also remembered reading the concerns reported by the man's solicitor to the custody officer.

27. The SO in reception said he clarified with the man that he wanted rule 45 status, and he confirmed he did. A governor was asked to approve the request and he was allocated to go to the Vulnerable Prisoners' Unit from reception. The SO recalled some of his conversation with the man. The man said that he felt betrayed, that voices in his head told him to commit the offence and he did not really understand what he was doing. He said he had been seeing a psychiatrist who decided to inform the police of his crime, and he felt betrayed by the breach of trust. The SO called the duty governor to reception as he was required to endorse the rule 45 request, which he did.
28. The man told the SO in reception that he felt embarrassed and ashamed. He was worried about the media interest as he was in a local jail, and felt he needed protection from any reprisals. The SO said he could see how worried the man was, so he explained the process for booking visits and seeing his family, telling him that he would be looked after. The man appeared to relax and become more comfortable after their discussion. The SO said he did not consider it necessary to begin the ACCT monitoring as he relayed his concerns to the reception nurse and healthcare. He then walked the man to the Vulnerable Prisoners holding room.
29. The man was next seen by the reception nurse. The nurse confirmed in interview that when he saw the man, he had a Cell Share Risk Assessment form (the CSRA assesses the risk a prisoner may pose to anyone he shares a cell with), the PER form and the Suicide/Self Harm Warning form.
30. The reception nurse knew the risks highlighted about the man before they talked together. He judged that there was no risk of self harm and at 6.40pm recorded "Elmley – not suicidal". The nurse said that he based his assessment on his interview with the man. He recalled that the man came across as very tearful and quite anxious. The nurse reassured him and they spoke about how he was feeling. The reception nurse referred to the notes he made during the interview and told my investigator that he spoke about a long history of psychological abuse. There were a lot of issues from his past which he wanted help with. The man said he had no intention of harming himself that evening, but felt vulnerable as it was his first time in prison.
31. The reception nurse added his comments to the CSRA. He identified that the man had been charged with a sexual offence, had abused drugs in the past, was dependent on drugs or alcohol and it was his first time in prison. The nurse added that the man's mood was low, but he was not suicidal. The nurse decided to refer him to the Primary Mental Health Team and doctors for a mental health assessment. He concluded that the man was low risk and able to share a cell (although he did not actually do so).
32. The reception nurse and the man also spoke about some physical problems affecting the man, which included ongoing knee problems and irritable bowel syndrome.
33. An Induction Portfolio was opened by the reception nurse, who also completed the Reception Check List. He confirmed that the court warrant had

been checked and explained, that he was to be placed on standard regime and there were no other concerns. The nurse also ticked the form to indicate that the man should be admitted to the inpatient facility in healthcare. He made an additional note that the man was low in mood, but not suicidal, it was his first time in prison and he wanted help with “his issues”.

34. The reception nurse told my investigator that he decided to admit the man into the prison’s inpatient healthcare facility as he was concerned about him. The man told the nurse that he was not thinking about harming himself, as he had a lot of support from his family and did not want to upset them anymore than he already had. The investigator asked the reception nurse why he did not place the man on an ACCT. The nurse said that he thought it was unnecessary because the man was going straight to healthcare. The reception nurse had given healthcare staff information at the handover (and information was also contained within his medical record). He judged that the man was in greater need of a psychiatric and mental health assessment. He believed the man would be safe for that night, before any healthcare assessments, and an ACCT was not needed.
35. The man told the nurse that he had been taking fluoxetine (an antidepressant medication). The reception nurse told healthcare this and the man was prescribed the medication the next day. The nurse also wrote in the medical record that the man needed a physical and mental health assessment. The nurse did not see the man again. He said that the man would have taken his property with him to healthcare and been given a meal (if he had not already had one in reception).
36. The man was taken to his cell that night by the first mental health nurse. She recalled that he arrived at healthcare about 8.00pm, as she was about to go home for the evening. He seemed very stressed and anxious and asked a lot of questions about prison life. The first mental health nurse said that, despite his presentation, she did not think he should be on an ACCT. The notes on his medical record said “low in mood but not suicidal” and he had no thoughts of self harm. The first mental health nurse added that the man did not tell her he had any intention of harming himself or taking his own life.
37. The next day was Good Friday, and the man was assessed by a second mental health nurse. The second mental health nurse also noted that the man appeared low in mood, complained of anxiety and said that he had been depressed over the past few months. The nurse concluded that he should have a further mental health referral in healthcare. My investigator asked why, if he was a mental health nurse, he did not carry out the assessment there and then. The second mental health nurse said it was because he was the nurse in charge on that day and so he had other responsibilities. The nurse said he could not remember whether he discussed a further mental health assessment with the man or not.
38. However, later that day, the first mental health nurse saw the man again. She noted in his medical records that his mood remained low, he was tearful and anxious about being in prison. He was offered lunch, but refused. A care

plan was established to monitor the man's mood, his behaviour and encourage him to take part in exercise and association with other prisoners. He was to be referred to the Mental Health Team for a further assessment because of his frame of mind. (Prisoners who are referred as a matter of urgency should be seen within 24 hours, non urgent in 72 hours and standard referrals seen within five to ten days.) The man's form was not marked as urgent as he was not considered to have expressed any suicidal ideas at that time. The first mental health nurse also noted that the man had refused lunch (although she said this was not unusual for new prisoners) and was encouraged to socialise with other prisoners.

39. The man was also interviewed that morning by a prison doctor and a nurse for a general medical assessment. He was found to have normal blood pressure, pulse rate and a healthy body weight. His medical history was recorded and he was prescribed fluoxetine antidepressants. The tablets were not to be held in his own possession, but were to be administered by a nurse at the appropriate times. An entry was made in the records noting that the man said that he attempted to take his life eight months previously, by driving his car into a wall. The doctor made an entry in the man's medical records after the assessment was completed. With regard to his mental health condition, the doctor said that the man had been suffering from anxiety and depression for the last three months. The doctor noted that it was the man's first time in prison, that he was not suicidal and had no thoughts of self harm. He added that the man had no history of over dosing, mental illness or psychosis. He also noted that the man had previously attempted suicide and was depressed. The doctor said that the man was fit for normal location (therefore ready to transfer into the main prison), was fit for the gymnasium, work and all other prison activities.
40. Also on the same day, the second stage of the man's induction was held. It is not clear where it took place, but it was likely to have been in healthcare. The man met a prison Insider (it is not clear from the documentation who this was) who explained to him how Elmley operated. (Insiders are prisoners who are trained to help with the induction process.) They discussed many aspects of prison life including what would happen in the next 24 hours. The Insider explained how the man could access the telephone and make calls, how to ask for visits, letters, canteen, property and applications. The man was also told about the role of the Listeners, and the prison's diversity and anti-bullying policies. The Insider also explained how the man could call for help in an emergency. He also provided various information about his cell (for example use of the television and power sockets).
41. The two men spoke about accommodation and the man confirmed that he had somewhere to live upon his release. The man said that he did not have any immediate health issues that he had not mentioned during his initial health screening, but did have an immediate drug or alcohol problem that needed addressing that he had not discussed during his reception. Both the Insider and the man signed this document. It is the last entry and it is unclear what action was taken to follow up the man's problem with alcohol or drugs.

42. The second mental health nurse remembered seeing the man in healthcare the next day (Saturday 11 April) but did not recall anything of note that day. There is only one entry in the medical records, which noted that the man appeared to have had a settled night.
43. A third nurse, saw the man during the day and recalled that he had spent some time in the day room, watched television and played pool. The nurse said that she did not notice anything which gave her cause to think that the man might harm himself.
44. An officer who was a member of the healthcare team, remembered speaking to the man, the morning of Sunday 12 April. He said that the man spent time playing pool and watching television, and that he seemed quite relaxed. The officer asked the man how he had slept and whether he was alright, and to come and find him if he felt he needed a chat.
45. Shortly afterwards, a fourth nurse, who was managing the Inpatient Unit, asked the third nurse to telephone the house blocks to see whether there was a cell available for the man. There were spaces on house block one. Shortly afterwards it was decided to transfer the man there even though he had not yet had his mental health assessment. Healthcare staff confirmed that it would not have been normal practice for a prisoner to remain in healthcare solely for this purpose and that the appointment would be arranged on the house block after the Easter holiday. The fourth nurse said he spoke to the man before he left healthcare and made an entry on EMIS (healthcare's computerised medical records system) that he appeared quite settled, did not appear depressed or distressed and had told the nurse that he was alright.
46. The third nurse recalled that, when the man was packing his belongings in healthcare for his transfer to the main prison, he asked which house block he would be going to. The third nurse told him that it would be house block one and the man asked whether that it was suitable for a vulnerable prisoner. The nurse confirmed that it was and he would be located on a spur for vulnerable prisoners. The man asked the third nurse if she could get him a bag for his possessions. He thanked her, and another member of staff, for helping him and explaining the prison regime to him.
47. Sometime later that morning, the officer who was a member of the healthcare team was told by a member of healthcare to take the man to house block one. (The officer could not remember who this was, although the evidence suggests that it was the third nurse.)
48. The officer from the healthcare team escorted the man to house block one and they spoke about general things as they walked over. The officer thought that the man had seemed chatty and relaxed. The officer handed over the man's paperwork (his history sheet) to an officer on house block one and returned to healthcare. A note was made in the man's personal history sheet by an officer (whose name is unreadable) which read that he had arrived on the wing from the healthcare's inpatient department. He was assessed as a low risk, non-smoking adult vulnerable prisoner and located onto C spur.

49. My investigator interviewed a prisoner who remembered seeing the man when he arrived on house block one. The prisoner saw him standing on the spur looking at him, and saying "alright". The prisoner replied "are you alright?" and walked up the stairs to his cell to get something he needed to take to the office. As he walked back down the stairs he saw him standing by the office. The prisoner said "how are you?" and the man replied "yes, I'm ok". The prisoner thought that he looked nervous. The prisoner asked him whether he had seen an officer, to which the man replied that he just wanted to speak to someone. He asked the prisoner what he had to do to speak to someone. The prisoner told him that there was usually an officer available, but it depended how busy they were.
50. An officer then appeared (the prisoner did not know who this was) and the man asked to speak to him. The officer replied that he was on his way to speak to an officer on the spur and walked away. The prisoner told the man not to worry, and that another officer would be along soon.
51. The man started to talk to the man. He told him that he was going to court the following Friday and hoped to be granted bail. The prisoner said the man seemed to cheer up as they were talking, although he was still nervous and shook up". They stood talking for a few minutes and spoke about different things, including football and what prison was like. The man said a few times that he wanted to talk to someone, telling the prisoner that he had come from healthcare and been put in a single cell. The prisoner said he did not recall the man speaking to any other prisoners or any member of staff before they were locked up for lunch approximately 20 minutes later.
52. The prisoner explained that prisoners collect their lunch from the canteen and return to their cell to eat. The man did not ask him how long lunch was or how long he would be locked in his cell. The prisoner said he did not recall seeing the man going to pick up his lunch and did not see him again that morning.
53. The first officer on the scene worked on house block one. He was working a late shift on 12 April and arrived on the wing at approximately 1.30pm. At approximately 3.15pm, he and a second officer began to unlock the man's spur for afternoon association. The second officer on the scene began to unlock the third floor landing while the first officer on the scene began to unlock the first floor. He was not carrying a radio.
54. As the first officer on the scene got to the man's cell (number 132), he opened the observation panel. He saw that the bed was made and a few belongings seemed to be there, but he could not see the man. The officer took another look through the panel but as he could still not see anyone inside the cell. He unlocked and opened the door, calling out to ask if the prisoner was alright, but got no response.
55. The first officer on the scene could see that the toilet door was open slightly and, being aware that a pool ball had gone missing from the house block that morning, cautiously called out again. He saw a shadow behind the toilet door

and what appeared to be the knuckles of a hand. Again, he got no response. The officer shut the cell door, closed the observation panel and went to check who was supposed to be in the cell. He saw that it was supposed to be the man. The first officer on the scene immediately saw the second officer on the scene, explained what had happened when he opened the man's cell and asked him to assist him.

56. Both officers went to the man's cell and the second officer on the scene repeated the same actions as the first officer on the scene. As the second officer on the scene got no response from the man, he secured the cell door into the open position and both officers went inside. Before they opened the toilet door, one of the officers again asked whether the man was okay. As they received no reply, they pushed the toilet door open. As they did so, the man began to fall to the floor. The second officer on the scene tried to break his fall and ease him gently to the floor, whilst the first officer shouted for help.
57. The second officer on the scene could see that the man had tied a ligature around his neck and to the toilet door. As the door opened, the ligature had become loose. The second officer immediately used his anti ligature knife to cut the ligature (which was made from a bed sheet). He checked the man's airway and for a pulse, but found none. He noticed that the man's tongue was swollen and that he had defecated. The second officer, who was first aid trained, immediately commenced chest compressions. He administered 15 compressions and checked for vital signs after every set of compressions.
58. In the meantime, the SO heard the first officer's call for assistance and ran to the cell. The SO immediately radioed a Code Blue emergency over the radio. (Code Blue is the emergency call which signals a person is not breathing and urgent medical assistance is required.) As she did not receive an immediate response, she pressed the general alarm bell (which would automatically raise healthcare staff). By then the Code Blue call had been acknowledged and an ambulance called as a matter of course (the records show the ambulance was called at 3.17pm).
59. The SO ran back to the cell, by which point a number of prisoners who had already been unlocked had started to gather around. She instructed officers to return the prisoners to their cells and re-entered the man's cell. By this time, a third officer who had been alerted by the general alarm, was present in the cell. The third officer also checked for signs of life and then took over chest compressions from the second officer on the scene. He had a resuscitation mask which the SO used to begin to administer mouth to mouth resuscitation. The SO recalled that she could not see the man's chest moving as she was administering breaths, and thought that his swollen tongue might have been preventing this. It was also hard to open the man's jaw (as rigor mortis had set in) but, as staff were not medically trained, they continued with cardio pulmonary resuscitation (CPR).
60. The second officer on the scene left the cell at this point to help return prisoners to their cells and the first officer on the scene remained in the cell.

The SO and the third officer continued CPR until the healthcare staff began to arrive.

61. The nurse who was Hotel One that day, which meant he was carrying the healthcare emergency radio and was designated as the first response to any emergency call. The emergency bag contained an oxygen cylinder, an ambu-bag (a device used to mechanically assist breathing) and a defibrillator (to detect whether there is any heart rhythm) amongst other things. He arrived at the cell within two or three minutes, bringing the emergency response bag with him. (My investigator was unable to interview the nurse who was Hotel one as he had moved to Australia.) The nurse who was Hotel one administered oxygen through the man's nose, as his jaw was locked and was unable to do so via his mouth.
62. The second nurse on the scene was already working on house block one when the alarm was raised. Before she could attend the emergency, she had to put the medicines away, lock the cabinet and lock up the room where she was working. After she had done so, she followed some officers to the man's cell. The second nurse on the scene immediately relieved the third officer and took over chest compressions.
63. Shortly afterwards, the healthcare officer (who was in healthcare when he heard the emergency call over the radio) arrived at the cell. He was followed by a fourth and third nurse and the Primary Care Manager. The healthcare officer took over chest compressions. He tried to open the man's jaw to administer oxygen but was unable to. Instead he inserted a nasal tube through the nasal cavity and down into the man's throat. The healthcare officer asked whether an ambulance was on its way, and was told that it was. He used a pulse oximeter to determine the level of oxygen in the man's blood. As staff were using a small oxygen cylinder from the emergency bag, a member of healthcare requested that another, larger, cylinder was brought over from healthcare.
64. CPR continued on the man until the paramedics arrived, some 20 minutes after the initial alarm was raised. The paramedics continued with CPR, with assistance from prison staff, until approximately 4.00pm. The paramedics said they were unable to formally pronounce the man dead, even though they were sure that he had died. A duty doctor was requested who arrived at the cell at 6.10pm, when he formally confirmed that the man had died. His records state:

“patient found hung in cell. Asked to certify death. Paramedics attended and left...pupils fixed and dilated. No heart or breath sounds. Certified time of death 6.13pm.”

The duty doctor coincidentally had been the man's doctor in the community and so was able to formally identify him.

65. The other prisoners at Elmley, and particularly those on house block one, were informed by letter that the man had died. The prisoners who were on an

ACCT at that time were reviewed and all the prisoners were reminded of the role of Listeners and the Samaritans service, should they feel they needed someone to speak to.

66. A hot de-brief for staff was held later that day. (The purpose of the meeting was for staff involved in the death of the man to discuss what happened and consider how effectively the procedures were followed.) A member of the Care Team spoke to staff about how they were feeling and coping with what had happened. The staff who spoke to my investigator spoke highly of the member of the Care Team and appreciated his care and attention.
67. At approximately 7.10pm, the prison chaplain and the prison governor visited the man's wife to explain what had happened. She asked that her father, the man's father-in-law be contacted, and a few minutes later her father arrived at her home. The reverend and the governor gave their contact details, along with those of the police investigator, the coroner and the NHS Bereavement Service.
68. The next day the reverend telephoned the man's father-in-law to ask after the family and whether they had any questions. The reverend discussed the man's property, whether the family wanted to visit the prison and the man's cell, and about funeral arrangements and expenses.
69. The reverend visited the man's father-in-law at his home on 14 April, when they discussed a number of issues. The chaplain handed over all the man's personal effects, promised to retrieve £25 that the man's father-in-law had handed in on his visit the previous Saturday, and discussed visiting the prison.
70. A post-mortem was held on 15 April. The cause of the man's death was confirmed as suspension. The toxicological analysis revealed no evidence of alcohol and drugs in his blood that could have contributed to his death, although cannabinoid levels suggested that he had smoked cannabis sometime prior to his death.
71. The man's father-in-law visited the prison the next day. At a meeting with the governor, he explained he had a number of questions about what had happened. The governor advised that the man's father-in-law should make a note of these for when he spoke to my investigator, the Ombudsman's investigator. The man's funeral was held two weeks later. The reverend asked whether the family would like himself or the Governor to attend the service, but the man's father-in-law declined.
72. The Governor wrote to all the staff involved in the attempted resuscitation of the man, thanking them for their help and commending their professionalism.

ISSUES

Why was the man not put on an ACCT whilst at Elmley?

73. The staff who assessed the man in reception considered that, although he had a history of self harm, suicide attempts and psychiatric problems, it was not necessary for an ACCT to be opened for him. They were satisfied that he had no suicidal ideas at that time. The nurse who saw the man was, however, concerned enough to locate him in healthcare, rather than on the house block. He believed that the man would be assessed there and any appropriate action taken by healthcare staff.
74. Although I understand the nurses took the action that they felt was most appropriate at that time, I believe that they should have given greater weight to the man's risk factors. The nature of his offence, the fact that it was his first time in prison and he was clearly upset, should have resulted in the ACCT monitoring being put in place. The man said that he was not thinking about harming himself, but it would have been a sensible safeguard for staff in either reception or healthcare to have opened the ACCT procedures.
75. Certainly as the man moved from healthcare before he had a full mental health assessment, consideration should have been given at that point about opening an ACCT before he transferred to house block one.

The Governor should ensure that all appropriate staff are ACCT trained and that all staff are aware that any staff member can, and should, open an ACCT on any prisoner they have concerns about.

Why was the man moved from healthcare before he had a full mental health assessment?

76. There was a difference of opinion amongst staff as to whether the man should have remained in healthcare whilst awaiting the assessment. Healthcare staff working in the inpatients department of healthcare said that the man was classed as a 'lodger' as he was not in healthcare for anything other than an assessment which could be carried out anywhere in the prison. Coupled with the fact that the prison doctor said the man was fit to be located on a house block, they believed that he could be moved from healthcare. As I say, no thought was given as to whether the man should be put on an ACCT at this point.
77. However, the Head of Healthcare, said during her interview for this investigation that the man should have stayed in healthcare until the mental health assessment had been carried out. This is clearly a breakdown in communications within healthcare. Given that it was a Bank Holiday weekend, that the man was upset at being in prison for the first time and the nature of his offence, it seems reasonable to me that he should have remained in a smaller, specialised department until he was assessed.

78. Another concern is that the man was assessed as fit for location on the house block by the doctor, in spite of information regarding his past attempts at harming himself and psychiatric issues. I believe that the doctor should have taken this into account and, in my opinion, instructed that he remain in healthcare until a proper assessment had been conducted, or until an ACCT was opened for him.

The Head of Healthcare should ensure that clear guidance is in place instructing when a prisoner should be moved from healthcare to normal location, and also that all documentation about the prisoner and a full handover is given to the receiving house block. Also, that all the prisoner's documentation is reviewed during the assessment by healthcare staff.

The decision to allocate the man to a single cell

79. Once the man moved to house block one he was located in a single cell. The CSRA carried out when the man arrived noted he was of low risk to others and could be located in a shared cell. However, I understand that a number of single cells were available as many prisoners from house block one had been transferred to another prison, leaving plenty of space available on the wing.

80. It was not possible to establish any other reason why the man was allocated a single cell, and no information was passed from healthcare to staff on house block one to suggest he should not be in a cell on his own. The CSRA looks at whether a prisoner is harmful to others, rather than themselves. However, whilst I make no formal recommendation here, the Governor will wish to consider whether a new and vulnerable prisoner, such as the man, should have been located in a cell on his own.

Settling in new and vulnerable prisoners onto a new house block

81. From the records, from talking to staff and a prisoner, it seems that the man was given very little assistance from staff to settle into the house block. Fortunately he spoke to another prisoner who was able to give my investigation an account of how the man was. The man clearly wanted to speak to a member of staff, but unfortunately the single officer he spoke to was not from his own house block. Rather than find a member of staff who could help, or take the time to speak to him himself, the officer (who has not been identified) seems simply to have told the man to find someone else himself. This officer would not have known any of the man's history and how important it could have been for him to speak to someone at the point. In my view, more care and humanity might well have helped the man at that time. It is disappointing that I feel the need to make a recommendation here, as I would expect any member of staff to have tried to help a new and vulnerable prisoner.

The Governor should ensure that staff are mindful of new prisoners settling onto a house block (in particular a vulnerable prisoner) and time should be taken to engage in a discussion with them and to read any accompanying documentation to establish any potential problems or issues.

Emergency response

82. The clinical reviewer makes the following recommendations, which I endorse. The large oxygen cylinder had to be brought some distance to the man's cell and it would be appropriate to assess the risk of locating cylinders around the prison, and closer to house blocks.

The Head of Healthcare should carry out a risk assessment to determine the viability of locating oxygen cylinders strategically around the prison.

83. The staff who were involved with the resuscitation attempt stated that they were using 15 chest compressions to two breaths. This advice has now been superseded and the current recommendation of the Resuscitation Council is to provide 30 compressions followed by two breaths. While I intend no criticism of the officers who attempted CPR, who acted according to the training they were given, it is important that training is refreshed regularly.

The Governor and the Head of Healthcare should consider a training programme to allow all staff to have up to date first aid training and practical tuition, preferably on an annual basis.

CONCLUSION

84. The man was clearly a vulnerable prisoner who required a higher degree of care and assessment than he received. At various points throughout his time at Elmley, I believe that the Prison Service's Assessment, Care in Custody and Teamwork support should have been provided. There were several factors which increased the risk that he would harm himself. He had a history of psychiatric illness, was charged with a serious offence and had not been in prison before. These alone should have alerted staff to the risks, especially given the fragility and vulnerability the man displayed.
85. It is also worrying that, given the man's history of harming himself and his well documented psychiatric problems, that he was assessed as suitable to be moved away from inpatient healthcare to a normal prison wing before he received a full mental health assessment. It is, of course, impossible to say whether this would have made any difference to the man or the actions he took, but it would have shown that staff did their very best to ensure that the man was as safe as he could be whilst in their custody.

RECOMMENDATIONS

To the Governor:

1. The Governor should ensure that all appropriate staff are ACCT trained and that all staff are aware that any staff member can, and should, open an ACCT on any prisoner they have concerns about.

Recommendation accepted by the prison

2. The Governor should ensure that staff are mindful of new prisoners settling onto a house block (in particular a vulnerable prisoner) and time should be taken to engage in a discussion with them and to read any accompanying documentation to establish any potential problems or issues.

Recommendation accepted by the prison

To the Head of Healthcare:

3. The Head of Healthcare should ensure that clear guidance is in place instructing when a prisoner should be moved from healthcare to normal location, and also that all documentation about the prisoner and a full handover is given to the receiving house block. Also, that all the prisoner's documentation is reviewed during the assessment by healthcare staff.

Recommendation accepted by the prison

4. The Head of Healthcare should carry out a risk assessment, to determine the viability of locating oxygen cylinders strategically around the prison.

Recommendation accepted by the prison

To the Governor and Head of Healthcare:

5. The Governor and the Head of Healthcare should consider a training programme to allow all staff to have up to date first aid training and practical tuition, preferably on an annual basis.

Recommendation partially accepted by the prison.